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MEDICAL REPATRIATION: THE DANGEROUS INTERSECTION OF HEALTH CARE LAW AND IMMIGRATION

KATELYNN DONELSON*

Apparently they see us as beasts of burden that can be dumped
back over the border when we have outlived our usefulness
*Jesús, the parent of a medically repatriated immigrant.*¹

I. INTRODUCTION

The aforementioned quote comes from the story of Antonio, a Mexican native that came to the United States.² Antonio obtained a visa to live and work in the United States.³ While living in the United States, he was in a car accident that resulted in “severe brain injury, bruised lungs, and other abdominal injuries.”⁴ He was taken to a hospital and was placed on a ventilator to keep him alive in a comatose-like state.⁵ The hospital quickly reached the conclusion that there was little to be done to help Antonio.⁶ It was suggested that Antonio be unplugged from the ventilator that was

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1. Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, N.Y. TIMES (Nov. 8, 2008), <http://www.nytimes.com/2008/11/09/us/09deport.html?pagewanted=all> [hereinafter *Deported in a Coma*].

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. See *id.* (noting that the hospital reached the medical conclusion that medical intervention would no longer help Antonio).

keeping him alive.⁷ Antonio's parents refused to give up on their son and rejected the hospital's suggestion.⁸ The hospital then took Antonio's care into their control, deciding to send Antonio back to Mexico.⁹ The hospital explained to his parents that because Antonio was an immigrant that had not been in the United States for the required five-year period, he was not eligible for federal financial assistance to pay for medical care.¹⁰ Antonio did not have private health insurance through his work as a farm laborer to cover medical costs,¹¹ and Antonio and his family could not pay for Antonio's medical care out-of-pocket.¹² Days after the hospital announced their decision to send Antonio back to Mexico, he was sent back in a comatose-state.¹³

Antonio's story is sadly common.¹⁴ Medical repatriation of undocumented or underprivileged alien patients has become a practice that is prevalent in hospitals across the United States.¹⁵ Medical repatriation is the cross point between health care law and immigration, and it has surfaced as a way for hospitals to comply with federal patient safety regulations by taking on functions of the Department of Homeland Security ("DHS").

Medical repatriation is the process by which uninsured aliens who suffer from long-term medical care needs are transferred from a United States hospital to a medical care facility in their country of origin.¹⁶ Medical repatriation has been swept under the rug and away from the media

7. *Id.*

8. *Id.*

9. *See id.* (stating that the hospital attempted to medically repatriate Antonio to his home country of Mexico).

10. *Id.*; *see also* ARIZ. REV. STAT. ANN. § 36-2903.03 (2011) (explaining that any legal permanent resident in Arizona must maintain legal permanent residency for five years before they are eligible to receive state Medicaid benefits in conjunction with 42 U.S.C.A § 1396b (2014)).

11. *Deported in a Coma*, *supra* note 1.

12. *See id.* (noting that attempts to give Antonio's family time to make other arrangements so that Antonio would not be medically repatriated proved unsuccessful).

13. *See id.* (noting that through the work of legal counsel, Antonio's parents were able to have Antonio returned to the United States to receive healthcare, but when he returned, he was still in a comatose state and suffering from potential septic shock).

14. *See* SETON HALL UNIVERSITY SCHOOL OF LAW CENTER FOR SOCIAL JUSTICE AND NEW YORK LAWYERS FOR THE PUBLIC INTEREST, DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS: A STUDY ON THE PRACTICE OF MEDICAL REPATRIATION at 5 (2012) [hereinafter DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS] (noting that the Seton Hall University School of Law Center for Social Justice and New York Lawyers for the Public Interest performed a study on medical repatriation over six years in 15 different states, encountering over 800 medical repatriations during this time, though they suspect that many repatriations remain undocumented).

15. *See id.* at 3 (demonstrating the extent of medical repatriation).

16. Joseph Wolpin, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152, 152 (2009).

spotlight. Hospitals and medical care facilities have not been forthcoming with the number of aliens repatriated, or the effects that repatriation has had on these aliens.¹⁷ One result of the lack of attention to the issue is that there are virtually no state or federal regulations that directly address the legality or the ethics behind medical repatriation.¹⁸ Nevertheless, studies have shown that medical repatriation is a prevalent practice in U.S. care facilities.¹⁹ The Center for Social Justice in collaboration with the Seton Hall Law School Immigration Rights/International Human Rights Clinic found that from 2006–2012, there had been over 800 documented attempted or completed medical repatriations across 15 states.²⁰ The study estimated that the number of undocumented medical repatriations each year is exorbitant.²¹

The driving force behind medical repatriation comes from the lack of funds in emergency care facilities.²² Most—if not all—undocumented aliens do not have access to health insurance nor to Medicare or Medicaid benefits.²³ The Emergency Medical Treatment and Active Labor Act (“EMTALA”)²⁴ provides that a hospital is not permitted to deny anyone emergency care nor transfer a patient to another care facility because of their inability to pay for medical care.²⁵ Therefore, when an alien needs long-term medical care and the hospital is unable to transfer the patient to

17. Compare Deborah Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES (Aug. 3, 2008), www.nytimes.com/2008/08/03/us/03deport.html [hereinafter *Deportation by U.S. Hospitals*] (explaining that typically, hospitals do not record the number of medical repatriations they perform), with DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14 (explaining that the clinic was able to do a study on the number of medical repatriations in 15 states across the United States, but that there are many unaccounted for medical repatriations).

18. Wolpin, *supra* note 16; see also Cruz v. Ctr. Iowa Hosp. Corp., 826 N.W.2d 516, *2 (Iowa Ct. App. 2012) (explaining that the only other case addressing the issue of medical repatriation is *Montejo v. Martin Mem’l Med. Ctr., Inc.*, 935 So. 2d 1266, 1268 (Fla. Dist. Ct. App. 2006)).

19. See generally DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14 (giving a general study of medical repatriations statistics from across the United States).

20. See *id.* at 5 The study evaluated the number of medical repatriations occurring throughout the United States, noting what happens to these alien patients after they are forced to return home. *Id.*

21. *Id.*

22. Wolpin, *supra* note 16. Hospitals frequently do not receive enough emergency medical funds from the federal government to make up for patient services that the patients are unable to pay for. *Id.* By medically repatriating the alien patient, the hospital is able to cut the cost of providing medical services to a patient that cannot pay for these services. *Id.*

23. DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 4; see also *Deportation by U.S. Hospitals*, *supra* note 17 (explaining that alien patients are not eligible to receive federally funded health care, and are infrequently eligible for health insurance provided through employers).

24. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2011).

25. DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 14; see also § 1395dd (2011).

another facility within the United States, the hospital is forced to pay for the alien patient's medical care.²⁶ Hospitals have therefore found a solution to avoid paying for long-term care for alien patients in medical repatriation: they ship and deport these sick patients back to their home country, with little regulation as to what requirements must be present to medically repatriate these sick aliens.²⁷ Once the patient is medevac-ed out of the hospital, the hospital acts as though their medical and legal requirements have been met, without regard to the potential violation of medical ethics.

This Article will explore EMTALA, and how hospitals and medical care facilities have manipulated the legal and ethical requirements of EMTALA to perform medical repatriations while remaining in technical compliance with the statute.²⁸ Part III examines the limited jurisprudence on medical repatriation, with a particular focus on *Cruz v. Central Iowa Hospital Corp.*²⁹ The *Cruz* case will present one of the many issues that come with medical repatriation: consent.³⁰ Part III discusses the two types of medical consent: the Reasonable Patient Standard, and the Professional Standard.³¹ Part IV suggests what informed consent—in terms of medical repatriation—should require,³² including the medical issues that should be discussed with the patient.³³ Part IV will also briefly divulge why informed consent needs to include a patient's understanding of the immigration consequences of medical repatriation.³⁴ This Article concludes with recommendations for how informed consent can protect aliens from medical repatriation.³⁵

II. EMERGENCY MEDICAL TREATMENT AND THE ACTIVE LABOR ACT

EMTALA was passed in 1986, and was passed by Congress as a response to hospitals and emergency rooms across the United States that

26. Wolpin, *supra* note 16, at 153 (explaining that hospitals have little chance of being reimbursed because the alien does not have health insurance, does not have access to public assistance healthcare, and in most cases, will not be able to compensate the hospital for the healthcare received out of their own pockets).

27. *See infra* Part II (explaining that hospitals are able to medically repatriate alien patients while remaining in compliance with EMTALA).

28. *See infra* Part II.

29. *See infra* Part III; *Cruz v. Ctr. Iowa Hosp. Corp.*, 826 N.W.2d 516 (Iowa Ct. App. 2012).

30. *See infra* Part III (explaining that the *Cruz* case is discussed in depth to explain one of the major issues in medical repatriation, i.e., consent of the patient).

31. *See infra* Part IV.

32. *See infra* Part IV.

33. *See infra* Part IV.A.

34. *See infra* Part IV.B.

35. *See infra* Part V.

participated in patient dumping.³⁶ Essentially, patient dumping occurs when a hospital refuses to treat a patient because the patient is uninsured and is unable to pay the out-of-pocket expenses for hospital care.³⁷ While the medical ethics of patient dumping may have been murky, it was considered to be within the hospital's right to deny emergency care, as the common law provided that hospitals have "no duty" to accept patients that could not pay for medical services.³⁸ With this problem in mind, Congress sought to take legislative action that would prevent hospitals from denying emergency medical treatment (including women that were in active labor of a child) to anyone that came into the hospital with an alleged emergency medical condition.³⁹ EMTALA looked to prevent patient dumping and ensure that no emergency care hospital turned patients away by employing a variety of different requirements that the hospital must meet in order to avoid civil penalties.⁴⁰

A. Medical Screening Requirement

Pursuant to 42 U.S.C.A. § 1395dd(a), any individual (or someone who is entrusted to make decisions on the behalf of an individual) that comes to a hospital emergency room (that receives federal funds) and requests either an examination of a medical condition or treatment for a medical condition must be provided with an appropriate medical screening by that emergency room to determine whether an emergency medical

36. Melissa K. Stull, Annotation, *Construction and Application of Emergency Medical Treatment and Active Labor Act (42 U.S.C.A. § 1395dd)*, 104 A.L.R. FED. 166 (1991); see also U.S. DEP'T OF HEALTH & HUMAN SERV., OFFICE OF THE INSPECTOR, GENERAL PATIENT DUMPING AFTER COBRA: ASSESSING THE INCIDENCE AND THE PERSPECTIVES OF HEALTH CARE PROFESSIONALS 1 (1988) (noting that patient dumping is defined by the Office of the Inspector General of the Department of Health and Human Services as "the transfer of unstable patients or refusal to render emergency treatment to patients based on grounds unrelated to need or the hospital's ability to provide services").

37. Stull, *supra* note 36, § 2.

38. *Id.*; see also RESTATEMENT (THIRD) OF TORTS § 37 (2012) ("An actor whose conduct has not created a risk of physical harm to another has no duty of care to the other unless a court determines that one of the affirmative duties provided in §§ 38-44 is applicable.").

39. Compare Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2011) (noting that hospitals with emergency care facilities may not refuse a potential patient on the basis of their inability to pay for medical services rendered), with *Gerber v. Northwest Hosp. Ctr., Inc.*, 943 F. Supp. 571, 573 (D. Md. 1996) ("Congress enacted Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 in response to growing concern that hospitals were "dumping" patients unable to pay, by either refusing to provide emergency medical treatment or transferring patients before their emergency conditions were stabilized." (citation omitted) (internal quotation marks omitted)).

40. See § 1395dd (requiring hospitals to provide a medical examination and stabilize the patient accordingly; a patient may only be transferred from the care of the hospital under a narrow set of exceptions).

condition exists.⁴¹ Pursuant to EMTALA, an emergency medical condition has been defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.⁴²

Courts have later defined an emergency medical condition as being in “imminent danger of death or a serious disability.”⁴³

B. Stabilization

Once the hospital has performed the appropriate medical screening and has determined that an emergency medical condition does exist, the hospital must then stabilize the emergency medical condition.⁴⁴ The hospital may have the option of transferring the patient to a different medical care facility in compliance with other EMTALA provisions if the physician determines that transfer to another medical facility could provide better medical care.⁴⁵

Stabilization of the emergency medical condition has been defined as:

provid[ing] such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).⁴⁶

41. *See id.* § 1395dd(a) (noting that EMTALA applies to all persons with emergency medical conditions, regardless of immigration status or inability of the patient to pay for medical services).

42. *Id.* § 1395dd(e)(1)(A)(i)–(iii).

43. *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990).

44. § 1395dd(b)(1)(A).

45. *See id.*, § 1395dd(b)(1)(B) (noting that transfer to another medical care facility is only appropriate if the hospital does not have the capacity to take care of the patient or if transfer to another care facility would provide the patient with better care).

46. *Id.* § 1395dd(e)(3)(A).

EMTALA only requires that hospitals stabilize the patient or transfer the patient to another facility that can care for the patient if the original hospital cannot provide adequate care.⁴⁷ Once the patient has been stabilized, the hospital technically owes no further duty of care to the patient in terms of continuing treatment.⁴⁸ Accordingly, the hospital is able to discharge the patient.⁴⁹

C. Discharge of Patient

For a hospital to discharge a patient, the hospital must follow and comply with federal discharge requirements in conjunction with EMTALA.⁵⁰ Any hospital that receives federal funds and participates in the Medicare or Medicaid program must comply with the federal discharge requirements, regardless of the patient's inability to pay or immigration status.⁵¹ The federal discharge standards require that there is a discharge plan for the patient, that the hospital carries out the discharge plan, and that the patient be transferred to any necessary additional medical facilities to follow up on needed medical care.⁵² Patients are to be informed of their options and work with physicians to create the best discharge plan for the patient.⁵³

A discharge plan can vary depending upon a patient's needs and medical condition.⁵⁴ Depending upon the emergency medical condition, some patients will be able to return home without any further need for care

47. See generally *id.* § 1395dd (noting that EMTALA prevents the hospital from merely transferring a patient to prevent patient dumping).

48. See *id.* § 1395dd(e)(3)(A) (indicating that once the patient has been stabilized, the hospital may transfer or discharge the patient).

49. See *id.* (noting that once the patient has been stabilized pursuant to EMTALA, the patient is ready for discharge or transfer); see also DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 14 (explaining that after a patient has been stabilized pursuant to EMTALA, the legal obligation of the hospital to the patient has ended).

50. See 42 C.F.R. § 482.43 (2004) (noting that federal discharge requirements hold that a hospital must appropriately discharge a patient to an appropriate facility).

51. See *id.* § 482.43(b)(1)(A) (explaining that a discharge plan is required for: (a) patients participating in the Medicare or Medicaid program; (b) any patient or guardian that requests a discharge plan; and (c) any physician that requests a discharge plan); see also 42 C.F.R. § 482.1(a)(1), (a)(3), (a)(5) (2012) (explaining that any hospitals that participate in Medicare and Medicaid must comply with applicable CFR provisions, which includes federal discharge requirements).

52. § 482.43(a)–(d).

53. *Id.* § 482.43(b)–(c).

54. See *id.* (noting that a discharge plan should be tailored to a patient and their needs to ensure adequate discharge).

after they have been stabilized.⁵⁵ Other patients, however, will require additional medical care even though their condition has been stabilized pursuant to EMTALA.⁵⁶ If the patient does require additional care after stabilization, such as nursing home care or going to a rehabilitation center, a hospital is permitted to transfer the patient to these medical care centers.⁵⁷ But these long-term care centers are not required to comply with EMTALA because they are not classified as emergency care centers.⁵⁸ These care centers are free to reject any patient because of their inability to pay for medical care.⁵⁹

Aliens who are treated in a hospital but who then require long-term care needs after receiving treatment are placed in a difficult situation. While the alien's condition may be stabilized pursuant to EMTALA, the person may still need long-term care that an emergency medical care center has no obligation to provide.⁶⁰ The alien patient, however, cannot be transferred out to a long-term care facility pursuant to federal discharge laws because these care facilities may reject a patient based on their inability to pay.⁶¹ Many alien patients cannot pay for the hospital costs out of pocket and do

55. An example of such an emergency medical condition could be a patient that requires stitches for a laceration. After the stitches are put in place, the laceration is not likely to materially deteriorate in its condition. Therefore, a patient may be discharged with no further obligation from the hospital.

56. For example, a emergency medical condition could be a patient that suffered a stroke. While the patient may be stabilized to the point that the condition will not materially deteriorate upon transfer or discharge from the hospital, they may still need long term care such as rehabilitation to relearn motor skills. *See Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990) (explaining that the patient was admitted into the hospital with the Intensive Care Unit for a stroke she suffered, but needed follow-up care with a rehabilitation center). Under EMTALA, a hospital is able to discharge this patient since they have been stabilized, even though further medical care may be necessary. *See id.* (holding that because the hospital had stabilized the patient's medical emergency or stroke, the hospital was able to discharge the patient to the care of her sister).

57. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(c) (2011); *see also* DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS *supra* note 14, at 14 (explaining that after a patient has been stabilized pursuant to EMTALA, the legal obligation of the hospital to the patient has ended).

58. *Compare* § 1395dd(a) (explaining that hospitals with emergency treatment centers are required to comply with the provisions set forth in § 1395dd), *with* DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 14 (explaining that because long-term care centers, such as a nursing home or rehabilitation center, are not emergency care facilities, they are not required to accept patients regardless of inability to pay for medical treatment).

59. *Compare* § 1395dd(a) (stating that EMTALA only applies to medical care facilities with emergency care centers), *with* DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 14 (noting that because long-term care facilities are not for emergency care, they are not required to accept any patient as a hospital with an emergency center is required to do).

60. *See* DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 14 (explaining that once the hospital stabilizes the patient, its obligation to the patient ends).

61. *Id.*

not have insurance.⁶² Hospitals are then also forced to make a difficult decision as to how to proceed with the patient's long-term medical care. The cost of care may be exorbitant, with few facilities willing to accept these patient aliens for long-term care pursuant to discharge requirements.⁶³ The hospital can continue to pay for long-term medical costs, which will be at the hospital's expense with essentially no chance of ever recovering that cost of medical care.⁶⁴ Discharging a patient who is in need of continuing medical care to the streets or to the patient's home is not considered an appropriate discharge within the federal regulations.⁶⁵ Hence, the hospital must either keep the patient or find a place for them to be legally discharged.

Medical repatriation has provided an "out" for both of these choices. Medical repatriation from the perspective of a hospital allows an alien patient to continue to get medical treatment for long-term care in their country of origin, saving the hospital from the cost of providing long-term care in the United States.⁶⁶ However, medical repatriation can be considered another form of patient dumping, in which hospitals are able to turn away patients due to their inability to pay for medical care. Medical repatriation forces aliens to return to their country of origin where the medical care facilities may not be able to adequately care for the medical needs of the alien as a care facility within the United States could.⁶⁷ Therefore, there is a substantial risk that the transfer to a care facility abroad

62. See *id.* at 4 (stating that frequently, aliens are not eligible for federal health benefits and are unable to pay insurance costs).

63. *Id.* at 14; see also Jennifer M. Smith, *Screen, Stabilize and Ship: EMTALA, U.S. Hospitals, and Undocumented Immigrants (International Patient Dumping)*, 10 HOUS. J. HEALTH L. & POL'Y 309, 325–26 (2010) (explaining that hospitals struggle to pay for uninsured patients as federal funds do not meet the financial need); see also Caitlin O'Connell, Note, *Return to Sender: Evaluating the Medical Repatriations of Uninsured Immigrants*, 87 WASH. U. L. REV. 1429, 1441 (2010) (explaining that various obstacles such as lack of federal funds and refusal of other medical care facilities to accept uninsured and underprivileged patients often force hospitals to pick up the extra costs of these patients with no chance of receiving any compensation).

64. Smith, *supra* note 63 (explaining that medical assistance provided by the federal government to hospitals is frequently insufficient for hospitals to treat the climbing amount of aliens within the United States).

65. Vishal Agraharkar, Note, *Deporting the Sick: Regulating International Patient Dumping by U.S. Hospitals*, 41 COLUM. HUM. RTS. L. REV. 569, 574 (2010) (explaining that federal discharge requirements pursuant to 42 C.F.R. § 482.43(d) (2012) hold that a discharge must be made to an "appropriate facility," which consists of "facilities that can meet the patient's assessed needs on a post-discharge basis and that comply with Federal and State health and safety standards").

66. *Deported in a Coma*, *supra* note 1 (explaining that hospitals have limited options with EMTALA because the hospital is either forced to continue to pay for the patient's medical care, or it can medically repatriate the patient, thereby cutting costs).

67. DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 14–16.

will result in the patient's material deterioration.⁶⁸ Almost 30 years after Congress moved to curb patient dumping through EMTALA, hospitals are violating the spirit of this law by using medical repatriation as a new form of patient dumping to some of the least advantaged individuals in the U.S. hospital system. Two such examples of sick alien patients falling through the cracks of these federal regulations are seen in the cases of *Montejo v. Martin Memorial Medical Center*⁶⁹ and *Cruz v. Central Iowa Hospital Corp.*⁷⁰

III. CASE LAW

As previously mentioned, medical repatriation of aliens and its harmful effects have not been widely publicized.⁷¹ The principal cases of *Montejo v. Martin Memorial Medical Center*⁷² and *Cruz v. Central Iowa Hospital Corp.*⁷³ have shed light on the legality and ethics of medical repatriation.⁷⁴ These two cases come from different circuits, which discuss the same issue: hospitals have circumvented federal laws by dumping aliens that require long-term care that a hospital is unwilling to provide because the patient could not pay for it.⁷⁵ In both cases, the plaintiffs were aliens coming from Latin countries to the United States.⁷⁶ The plaintiff aliens were both unable to pay for their needed long-term medical care, and the hospital medically repatriated the alien patients while remaining in compliance with EMTALA.⁷⁷ After the alien patients were medically repatriated, the plaintiffs sued the respective hospital that deported them in

68. See Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(e)(3)(A) (2011) (explaining that a hospital has not abided by EMTALA provisions if there is a substantial risk of a material deterioration of the patient's condition).

69. 935 So.2d 1266 (Fla. Dist. Ct. App. 2006).

70. 826 N.W.2d 516 (Iowa Ct. App. 2012).

71. See *supra* Part I (explaining that hospitals have not been forthcoming with the numbers of patients that have been medically repatriated).

72. 935 So. 2d 1266.

73. 826 N.W.2d 516.

74. See *id.* at *2 (noting that the court mentioned that medical repatriation is an issue that has not been addressed by the government); see also *Montejo*, 935 So. 2d 1266 (the principal case on the issue of medical repatriation).

75. Compare *Montejo*, 935 So. 2d at 1267 (noting that the patient in Florida needed long-term medical care for the medical injuries sustained in a car accident), with *Cruz*, 826 N.W.2d at *1 (noting that the patient in Iowa needed long-term medical care for medical injuries sustained in a car accident).

76. See *Montejo*, 935 So. 2d at 1267 (noting that the alien was from Guatemala); *Cruz*, 826 N.W.2d at *1 (noting that the alien was from Mexico).

77. See *Montejo*, 935 So. 2d at 1267–68 (noting that the alien was medically repatriated to Guatemala); *Cruz*, 826 N. W.2d at *1 (noting that the alien was medically repatriated to Mexico).

separate proceedings.⁷⁸ Both alien plaintiffs sought to recover on the tort theory of false imprisonment.⁷⁹ Both courts found, however, that the plaintiffs could not satisfy all elements of a false imprisonment claim to recover from the defendant hospitals.⁸⁰ This Article will briefly examine the *Montejo* case and its repercussions on the legality of medical repatriation.⁸¹ The focus of this section, however, will be on the *Cruz* case, and how the court mistakenly found consent to transfer the plaintiffs to their home country of Mexico.⁸²

A. *Montejo v. Martin Memorial Medical Center*

Mr. Luis Alberto Jimenez is a citizen of Guatemala.⁸³ Mr. Jimenez was living in the United States without legal citizenship and did not have any health insurance.⁸⁴ In February of 2000, Mr. Jimenez was struck by a drunk driver, which resulted in severe brain damage and other physical injuries to his person.⁸⁵ Mr. Jimenez was taken to Martin Memorial Hospital and remained there until June of 2000 to receive care for his injuries.⁸⁶ The injuries rendered Mr. Jimenez incompetent to make any decisions.⁸⁷ After a short period of discharge, Mr. Jimenez was forced to return to Martin Memorial Hospital in January of 2001 on an emergency basis.⁸⁸ It was becoming increasingly evident that Mr. Jimenez was going to require long-term care for his medical injuries from the car crash.⁸⁹ Martin Memorial Hospital became concerned that Mr. Jimenez would not

78. *Montejo*, 935 So. 2d at 1268; *Cruz*, 826 N.W.2d 516 at *1.

79. *Montejo*, 935 So. 2d at 1268; *Cruz*, 826 N.W.2d at *2.

80. Compare *Montejo v. Martin Mem'l Med. Ctr.*, 2009 WL 3260347 (Fla. Cir. Ct. July 27, 2009) (noting that the alien was unsuccessful in recovering against the defendant hospital), with *Cruz*, 826 N.W.2d at *6–7 (noting that, like *Montejo*, the alien was unsuccessful in recovering against the defendant hospital).

81. See *infra* Part III.A.

82. See *infra* Part III.B.

83. *Montejo*, 935 So. 2d at 1267.

84. *Id.*

85. *Id.* The person that struck Mr. Jimenez had a blood alcohol level that was four times the legal limit. *Deportation by U.S. Hospitals*, *supra* note 17. The hospital was willing to take Mr. Jimenez and treat him for so long because of the possible insurance pay-out from the drunk drivers' car insurance. *Id.* After the drunk driver was convicted for criminal charges relating to the accident, it was found that he did not have car insurance. *Id.* There was an attempted recovery from the driver's work insurance since the drunk driver used the company truck to hit Mr. Jimenez. *Id.* This was also unsuccessful. *Id.*

86. *Montejo*, 935 So. 2d at 1267.

87. *Id.* (noting that Mr. Montejo Gaspar Montejo was appointed as the guardian and decision maker for all matters regarding Mr. Jimenez's person and property).

88. *Id.*

89. *Id.*

be able to pay for the medical care that he was receiving from the hospital, and would not be able to pay for future required medical care.⁹⁰ As a result of this concern, Martin Memorial Hospital sought permission from the circuit court to have Mr. Jimenez returned to his home country of Guatemala.⁹¹ The hospital asserted that Martin Memorial Hospital was not the appropriate facility to take care of Mr. Jimenez's medical needs.⁹² Martin Memorial was granted authorization to transport Mr. Jimenez back to Guatemala.⁹³

The District Court of Appeals of Florida, in a later decision, reversed the trial court's finding that Martin Memorial Hospital was authorized to transport Mr. Jimenez back to Guatemala.⁹⁴ Not only did the court find that Martin Memorial Hospital had failed to meet the federal discharge requirements by proving that the medical care facility in Guatemala would provide adequate care, but the court found that the circuit court did not have the subject matter jurisdiction to make such an authorization.⁹⁵ Mr. Montejó then brought a false imprisonment tort claim on behalf of Mr. Jimenez, alleging that the hospital had falsely imprisoned Mr. Jimenez during his transportation back to Guatemala.⁹⁶ Martin Memorial Hospital filed a motion to dismiss Mr. Montejó's claim, which the trial court granted.⁹⁷ Mr. Montejó brought the subsequent appeal before the District Court of Appeals of Florida, alleging that the motion to dismiss was improper.⁹⁸

The question before the court was whether Martin Memorial Hospital was granted immunity from tort liability for an order that was later determined to be invalid due to lack of subject matter jurisdiction.⁹⁹ The court found that to answer this question, the case needed to be remanded to a lower court to determine whether Martin Memorial Hospital's actions were unreasonable and unwarranted.¹⁰⁰ In 2009, a jury in the trial court

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. *Montejo v. Martin Mem'l Med. Ctr.*, 874 So. 2d 654, 658 (Fla. Dist. Ct. App. 2004).

95. *Id.*

96. *Montejo*, 935 So. 2d at 1268.

97. *Id.* (noting that Martin Memorial Hospital filed a motion to dismiss, alleging that Mr. Montejó did not have standing to bring the suit and that he could not demonstrate that the confinement was unwarranted and unreasonable).

98. *Id.* (explaining that in Mr. Montejó's appeal, he alleged that the court committed error in granting the motion to dismiss because he had standing to bring the suit and he could meet all the elements of a tort false imprisonment claim to allow for recovery in the case).

99. *Id.* (finding that Mr. Montejó did have standing to bring the claim, the court shifted its focus to the tort false imprisonment claim).

100. *Id.* at 1272 (noting that the court reversed and remanded the motion to dismiss that was granted by the lower court).

found that Martin Memorial Hospital's action of deporting Mr. Jimenez was not unwarranted or unreasonable.¹⁰¹ Therefore, Martin Memorial Hospital could not be held liable for a false imprisonment tort, and Mr. Jimenez could not recover.¹⁰² As of 2009, Mr. Jimenez is living in his small hometown of Guatemala with his mother.¹⁰³ He receives little medical care, suffers from seizures, and has the mental capacity of a grade-school child.¹⁰⁴

The jury verdict that Mr. Montejo could not prevail on a false imprisonment claim has set the standard for other courts to potentially follow in regards to medical repatriation cases.¹⁰⁵ The jury verdict in this case effectively serves as a green light for hospitals to continue with medical repatriations of aliens without fear of tort liability. With no jurisprudence from the courts as to whether or not medical repatriation is within the spirit of EMTALA, and with no legislative response from Congress on this issue, the court here undermined the spirit of EMTALA. The court essentially ruled that a hospital participating in medical repatriation is not imprisoning the alien. Hospitals can then assert that they are in compliance with EMTALA because they have met their legal obligation to stabilize the patient, and then, with permission from the court, can discharge them abroad.

While there has been little jurisprudence on the issue of medical repatriation, the *Montejo* case can serve as an effectual bar for future claims of false imprisonment for aliens that have been deported from other hospitals across the country. One such case where an alien attempted to bring a false imprisonment claim and was unsuccessful is the *Cruz* case.¹⁰⁶

B. *Cruz v. Central Iowa Hospital Corporation*

In May of 2008, Mr. Jacinto Rodriguez-Cruz and Mr. Jose Rodriguez-Saldana were driving home when a semi-truck hit them.¹⁰⁷ They were

101. *Montejo v. Martin Mem'l Med. Ctr.*, 2009 WL 3260347 (Fla. Cir. Ct. July 27, 2009); see generally Deborah Sontag, *Jury Rules for Hospital That Deported Patient*, N.Y. TIMES (July 28, 2009), www.nytimes.com/2009/07/28/us/28deport.html [hereinafter *Jury Rules*] (explaining generally that the jury found that Martin Memorial Hospital did not falsely imprison Mr. Jimenez, and therefore was not liable for damages).

102. *Montejo*, 2009 WL 3260347; *Jury Rules*, *supra* note 101.

103. *Jury Rules*, *supra* note 101.

104. *Id.*

105. *Cf. Cruz v. Ctr. Iowa Hosp. Corp.*, 826 N.W.2d 516, *2 (2012) (finding that there is little jurisprudence on the issue of medical repatriation); *Montejo v. Martin Mem'l Med. Ctr.*, 935 So. 2d 1266 (Fla. Dist. Ct. App. 2006) (serving as the only case law on this issue).

106. 826 N.W.2d 516.

107. *Id.* at *1.

undocumented aliens from Mexico.¹⁰⁸ Both men were ejected from their vehicle and as a result, they suffered severe brain injuries; both men were taken to the Iowa Methodist Medical Center for treatment.¹⁰⁹ The hospital realized that both men would need long-term medical care as a result of their injuries.¹¹⁰ The hospital set to work on a discharge plan for the patients that included deportation to Mexico to receive continued medical care abroad.¹¹¹ The hospital deported both men to a healthcare facility in Vera Cruz, Mexico; while their condition was stable at the time of return to Mexico, they both were in a semi-comatose state.¹¹² Upon their return to Mexico, both Mr. Cruz and Mr. Saldana brought suit against the Central Iowa Hospital Corporation.¹¹³ Both men alleged that the hospital was in violation of EMTALA, and that they were falsely imprisoned during their repatriation.¹¹⁴ The hospital responded with a motion for summary judgment, arguing that they had complied with all EMTALA requirements since the men were stabilized when they left the hospital; they also contested the false imprisonment claim.¹¹⁵ Both plaintiffs dropped the EMTALA violation claim but maintained that they were falsely imprisoned by the hospital when they were deported back to Mexico.¹¹⁶ The trial court disagreed with the plaintiffs, reasoning that the plaintiffs' detention was a result of their medical conditions—not a detention by the hospital when the hospital transported them to Mexico.¹¹⁷ The trial judge dismissed the plaintiffs' claims, which gave rise to the appeal at issue before the Court of Appeals of Iowa.¹¹⁸

The court began its analysis by examining medical repatriation, describing it as “a practice that is driven by financial considerations.”¹¹⁹ With a solid understanding of the complexity behind medical

108. *Id.*

109. *Id.*

110. *Id.*

111. *See id.* The social worker in charge of the discharge plan called various medical facilities in the area to determine if they would accept the two alien patients for long-term care. *Id.* All contacted facilities refused to take them because they were undocumented aliens. *Id.*

112. *Id.* (noting that the men only stayed in the medical care facility in Vera Cruz, Mexico for approximately one month before they were discharged from care).

113. *Id.*

114. *Id.* The alien plaintiffs additionally filed a loss of consortium claim as both the wives of both men were living in the United States when they were sent back to Mexico. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.* at *2 (noting that the court found it necessary to delve into the issue of medical repatriation to better understand the case).

repatriation,¹²⁰ the court recognized that there is little jurisprudence on the issue.¹²¹ With this background in mind, the court progressed through a false imprisonment tort claim to determine whether or not the plaintiff aliens were falsely imprisoned when they were medically repatriated.¹²² The court presented the two required elements that must be present to successfully establish a false imprisonment claim: (1) detention or restraint against a person's will, and (2) unlawfulness of the detention.¹²³ The court began by looking at the "detention or restraint against a person's will" element, which turns on consent.¹²⁴

The hospital asserted that the plaintiffs' families consented to the plaintiffs' return to a medical facility in Vera Cruz, Mexico.¹²⁵ The families vehemently maintained that they did not consent to having the plaintiffs return to Mexico;¹²⁶ they argued that even if consent could be inferred, it was done through misrepresentation because the families wanted the two men to remain in the United States.¹²⁷ The court, however, found consent to the medical repatriation through the families' lack of vehement objection.¹²⁸ The court reasoned that because the plaintiffs' families did not adamantly object to the transfer of the plaintiffs, they effectually consented to medical repatriation.¹²⁹ Therefore with this "consent" in mind, the court found that the plaintiffs could not meet the first element of the false imprisonment tort claim.¹³⁰

The court proceeded to the next element of a false imprisonment claim, and again found that the plaintiffs were unable to satisfy this

120. *Id.*; see also Philip Cantwell, Short Essay, *Relevant "Material": Importing the Principles of Informed Consent and Unconscionability to Analyze Consensual Medical Repatriations*, 6 HARV. L. & POL'Y REV. 249, 252 (2012) (noting that the court references Cantwell to understand medical repatriation, including why and how they occur).

121. *Cruz*, 826 N.W.2d at *2 (noting that *Montejo v. Martin* Mem'l Med. Ctr., 935 So. 2d 1266 (Fla. Dist. Ct. App. 2006) is the only other case that looks at the issue and legality of medical repatriations).

122. *Id.* at *3–7.

123. *Id.* at *3.

124. *Id.*

125. *Id.*

126. *Id.* The families of the plaintiffs submitted affidavits to the court contending that they never gave their consent to medically repatriate the plaintiffs. *Id.* But the social worker that made the arraignments for the repatriation alleges that she discussed the repatriation with the families and that they were aware of the consequences. *Id.*

127. *Id.* at *3–4. The families may have worked with the hospital social worker in the medical repatriation of the patients, but they claim that they ultimately did not want medical repatriation to occur. *Id.* Hence, any consent that the courts could infer was obtained through the hospital allegedly misrepresenting the situation to the plaintiffs' families. *Id.*

128. *Id.*

129. *Id.* at *4 ("Although the families say they never consented to the patient's transfer to the hospital in Vera Cruz, Mexico, neither did they object to it.").

130. *Id.*

element.¹³¹ To analyze this element of “unlawful detention,” the court looked to the Restatement (Second) of Torts, which holds that a false imprisonment claim is only established if (a) the person knows that they are being falsely imprisoned, and (b) if the alleged damages relate to the emotional harm of this imprisonment.¹³² The plaintiffs asserted that they were harmed by the confinement in the sense that they did not receive adequate medical care upon their return to Mexico, causing them to deteriorate.¹³³ The court rejected this argument, reasoning that it was not the hospital’s fault that the plaintiffs received poor medical care in Mexico.¹³⁴ The court further reasoned that no emotional harm could have occurred because the plaintiffs were not aware of their confinement, and only learned of such confinement upon waking up in Mexico.¹³⁵ Therefore, the court ultimately held that the alien plaintiffs could not recover under a false imprisonment tort claim.¹³⁶

The court’s reasoning in terms of consent in *Cruz* is troubling.¹³⁷ The ruling establishes a dangerous precedent for future jurisprudence on medical repatriation. The court explained that the hospital obtained the patients’ consent to medically repatriate them back to Mexico because they did not affirmatively object to their return to Mexico.¹³⁸ The implicated holding of *Cruz* is that if an alien patient does not blatantly object to medical repatriation, the hospital is compliant with EMTALA and federal discharge laws, and is within its right to deport the alien. Further, the holding in *Cruz* suggests that hospitals are free to infer consent because the patient is unable to affirmatively reject a medical procedure. The court effectually holds that an alien patient’s failure to state their objection while in a semi-comatose state equates to affirmatively stating “I want to return to

131. *Id.* at *4–7.

132. *See* RESTATEMENT (SECOND) OF TORTS § 35 (1965) (stating that liability for false imprisonment turns on the fact that (a) the individual intends to confine the other or a third person within boundaries fixed by the imprisoner, and (b) the individual’s act directly or indirectly results in such a confinement, and (c) the confined person is conscious of, or harmed by, the confinement); *see also Cruz*, 826 N.W.2d at *4 (explaining that the plaintiffs do not squarely fit in to what is required to establish unlawful detention); RESTATEMENT (SECOND) OF TORTS § 905 (1979) (“Compensatory damages that may be awarded without proof of pecuniary loss include compensation (a) for bodily harm, and (b) for emotional distress.”).

133. *Cruz*, 826 N.W.2d at *5.

134. *Id.* at *5–6.

135. *Id.* at *6 (noting that when the plaintiffs were repatriated, they were in a semi-comatose state and unresponsive, so therefore no emotional damage resulted from the medical repatriation itself).

136. *Id.* at *6–7.

137. *See id.* (noting that the alien plaintiffs were unable to recover on their false imprisonment claim as the court found that the plaintiffs consented to their return to Mexico because they did not object to their return to Mexico).

138. *Id.* at *3–4.

my home country.” It does not follow, however, that consent has been obtained because no objection has been given. A patient’s failure to give consent to a medical procedure should equate to lack of consent to complete a medical procedure—not that lack of objection equals consent. This seems especially true in light of the fact that the plaintiffs were in a semi-comatose state and therefore incapable of understanding the medical choices before them.

Informed consent requires discussing a patient’s options with the patient.¹³⁹ It does not follow that consent is achieved when the hospital has not fully discussed with the patient their options and consequences in a medical situation. This is particularly evident in *Cruz*, as the plaintiffs and their families were not made aware of their choices—they were simply told that the plaintiffs were returning to Mexico.¹⁴⁰ There is no evidence from the record that the hospital discussed what medical care would be like when the plaintiffs returned to Mexico.¹⁴¹ The *Cruz* court therefore seems to stray from well-established medical standards in this holding. Furthermore, finding consent in a situation where the patient cannot actually give consent seems contrary to well established standards in medical ethics.¹⁴² The reason why standards in medical decision-making are important is because of the idea that patients should be in charge of their bodies;¹⁴³ the idea of informed consent arose to prevent liability from battery.¹⁴⁴ The court seems to completely disregard the idea of patient autonomy. It appears that in this case, the court was looking to circumvent the legality of medical repatriation. Rather than address the issue of medical repatriation, the court oddly finds that there was informed consent in order to avoid the issue.

The court’s holding that the plaintiffs were unable to satisfy the elements of a false imprisonment claim is also troublesome. The court reasoned that because of the plaintiffs’ “consent” to medical repatriation, there was no detention against the plaintiffs’ will.¹⁴⁵ Having previously discussed the inadequacy of this “consent,”¹⁴⁶ the court continues to assert

139. See *infra* Part IV.

140. See *Cruz*, 826 N.W.2d at *1 (noting that the record reflects that the hospital only gave the patient’s family the option of medical repatriation and working with the families to medically repatriate the patients—the patients’ families were not given options to allow the patients to stay in the United States).

141. See *id.* (noting that the record does not reflect that the hospital investigated what the medical capabilities of the receiving hospital in Mexico would be like and how they would meet the medical needs of the alien patients).

142. See *infra* Part IV.

143. Steven E. Pegalis, *Informed Consent: Introduction*, 1 AM. LAW MED. MALP. § 4:1 (2005).

144. *Id.* (noting that any unwanted touching technically constitutes battery, so informed consent is necessary before the doctor can touch the patient to prevent tort liability).

145. *Cruz*, 826 N.W.2d at *4.

146. See *supra* Part III.

that the plaintiffs failed to satisfy the second element of a false imprisonment claim: the unlawfulness of the detention.¹⁴⁷ The court claims that the material deterioration of the plaintiffs' condition was not the hospital's fault.¹⁴⁸ A prima facie argument can be made, however, that but for the hospital transferring the plaintiffs back to Mexico, there would not have been a material deterioration of their medical conditions. It seems harsh for the court to assume that the plaintiffs suffered no emotional damage from the medical repatriation because they were in a semi-comatose state.

The court did not allow the plaintiffs to recover on the false imprisonment tort claim.¹⁴⁹ The holding effectually reinforces the *Montejo* holding, which also held that the alien patient could not recover on a false imprisonment claim.¹⁵⁰ While both of these cases come from different jurisdictions, it lays out a dangerous precedent for other federal circuits to look to when another medical repatriation case undoubtedly arises.¹⁵¹ The denial of a false imprisonment tort claim in both cases signifies that aliens will be unable to recover in future medical repatriations, and that medical repatriation is in compliance with EMTALA and federal discharge laws.¹⁵² *Cruz* is flawed based on legal precedent for informed consent.¹⁵³ Therefore, legal advocates should look to challenge the grounds on which *Cruz* was found—namely that the plaintiff aliens gave consent.

The *Montejo* and *Cruz* opinions therefore establish a disheartening future for medically repatriated aliens. It becomes clear from the opinions that one potential solution to these dangerous precedents is requiring informed consent from the alien patient. Requiring hospitals to obtain informed consent from an alien patient before medically repatriating them

147. *Cruz*, 826 N.W.2d 516 at *4–7.

148. *Id.* at *6 (stating that the court reasoned that any medical deterioration in the plaintiff's condition was a result of the care that the alien patients received abroad—not as a result of the medical repatriation itself).

149. *See generally id.* (noting that the court found that the alien plaintiffs were unable to recover on their tort false imprisonment claim because they did not meet the elements of the claim).

150. *Compare id.* (noting that similar to the *Montejo* case, the court in *Cruz* found that the alien patients were unable to recover on a false imprisonment claim), with *Montejo v. Martin* Mem'l Med. Ctr., 935 So. 2d 1266, 1272 (2006) (noting that the court found that the alien patient could not recover against the hospital in a false imprisonment claim).

151. While the cases were not decided by the Federal Court of Appeals, they could still be used as precedent since they did come from different circuits that could be relied upon. *Montejo*, 935 So. 2d 1266 was decided in Florida, which sits in the 11th Federal Circuit. *Cruz*, 826 N.W.2d 516 was decided in Iowa, which sits in the 8th Federal Circuit.

152. Both the *Montejo* and *Cruz* decisions denied the alien patient recovery on their false imprisonment tort claims. *See supra* Part III.

153. *See infra* Part IV (noting that informed consent requires discussing a patient's options with the patient before they are able to make a decision as to their medical care).

could serve as a bar to medical repatriation.¹⁵⁴ Requiring informed consent from alien patients would serve as a blatant objection to medical repatriation. Therefore, in conjunction with the holding in *Cruz*, this blatant objection to medical repatriation would bolster the viability of a false imprisonment claim, and would serve to stop hospitals' practice of medical repatriation.¹⁵⁵ It is imperative that courts consider requiring hospitals to obtain an alien patient's informed consent before medically repatriating an alien patient.

IV. THE IMPORTANCE OF INFORMED CONSENT

Informed consent can serve as a potential bar to hospitals medically repatriating sick alien patients.¹⁵⁶ The common law requirement of obtaining a patient's informed consent is an especially vital tool in protecting an alien patient from a forced medical repatriation since other health statutes and regulations are ineffective. As previously mentioned, EMTALA only requires that the patient is stabilized in order to prevent any material deterioration of the medical condition.¹⁵⁷ Once the patient is stabilized, the hospital owes the patient no further duty of care.¹⁵⁸ Furthermore, federal discharge laws do not provide a safeguard against medical repatriation.¹⁵⁹ Pursuant to 42 C.F.R. § 482.43(d), a hospital is able to transfer a patient to another facility that will provide medical care, yet many long-term care facilities reject patients on the basis of their inability to pay.¹⁶⁰ Additionally, once an alien has been transferred to a center abroad, the Department of Health and Human Services loses its jurisdiction to follow-up with the patient to ensure that appropriate medical care is

154. See Cantwell, *supra* note 120, at 257 (explaining that consent is one of the various methods that can be used to stop medical repatriation or at least give it more legal respect); see also DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 9 (noting that informed consent is something that hospitals should strive to achieve, and without such consent, an alien should not be medically repatriated).

155. *Cruz*, 826 N.W.2d at *4 (holding that because the patients did not object to their medical repatriation, they essentially consented to medical repatriation).

156. See Cantwell, *supra* note 115, at 257–60 (explaining that informed consent can stop medical repatriation); see also DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 9 (noting that requiring informed consent can stop hospitals from medically repatriating aliens).

157. See *supra* Part II.

158. See *supra* Part II.

159. See *supra* Part II.

160. See 42 C.F.R. § 482.43(d) (2004) (“The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow up or ancillary care.”).

being provided.¹⁶¹ Other than these two provisions, there are no other federal regulations relating to medical repatriation.¹⁶²

Informed consent needs to be obtained by an alien patient (or their guardian) before a hospital can medically repatriate the alien patient.¹⁶³ If an alien is required to explicitly consent to any and all medical procedures, including their transfer to medical facilities abroad, it would prevent an emergency care hospital from deporting aliens if informed consent is not given by the alien patient (or their guardian).¹⁶⁴ Furthermore, refusal to give informed consent could serve as an obvious objection to medical repatriation, as *Cruz* would appear to require proof for a claim of false imprisonment.¹⁶⁵ Informed consent, in the sense that the alien patient merely understands that they would return to their country of origin, should not constitute informed consent to medical repatriation.¹⁶⁶

In the context of medical repatriation, informed consent should include an emergency care center that would clearly explain to the alien patient (or the alien patient's guardian) in the language in which they are most comfortable, the medical and potential immigration ramifications of medical repatriation. This would serve to prevent medical repatriation, as hospitals would have to ensure that aliens fully understand the consequences of returning to their home country instead of merely telling them that they are returning to their home country. Informed consent with these requirements would ensure that alien patients understand what they are agreeing to and its consequences. This is not to say that all aliens will reject medical repatriation and choose to stay within the United States. Rather, it ensures that the alien will be able to make their own medical decisions as all United States citizen patients are permitted to do.

161. DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 27–28.

162. Wolpin, *supra* note 16.

163. *Id.* at 259–60.

164. *Id.* at 152 (explaining that requiring informed consent before repatriation would offer aliens protection, as the hospital is unable to perform a medical procedure without the patient's consent).

165. See *Cruz v. Ctr. Iowa Hosp. Corp.*, 826 N.W.2d 516, *4 (Iowa Ct. App. 2012) (explaining that because the alien plaintiffs did not obviously object to the medical repatriation, they were essentially giving their consent to the medical repatriation).

166. See DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 29, 32–34 (explaining that there are various considerations that need to be accounted for to determine whether an alien has given informed consent in their choice to return to their country of origin); see also Cantwell, *supra* note 120, at 259 (suggesting that informed consent should consist of informing the alien patient of immigration consequences, post-transfer health consequences, treatment options, and payment responsibilities).

A. Achieving Medical Informed Consent

In general, informed consent requires that all material information be disclosed to a patient before they choose to go forward with any medical procedure.¹⁶⁷ There are, however, two standards that are accepted within both the legal and medical community to determine if informed (medical) consent has been achieved.¹⁶⁸ The arguably more widely accepted method of obtaining informed consent is the professional standard.¹⁶⁹ The professional standard dictates that the physician is best suited to understand the medical endeavor that the patient is to embark on.¹⁷⁰ Therefore, what needs to be disclosed to achieve informed consent is based upon what a reasonable physician would find necessary to disclose to the patient based upon the circumstances.¹⁷¹ The other way that informed consent can be achieved is through the reasonable patient standard, or the materiality standard.¹⁷² The reasonable patient standard dictates that that the patient is not able to give informed consent without hearing everything that a reasonable patient would want to know about the medical procedure, medical risk, etc.¹⁷³

While both standards of informed consent come with their respective merits, it is clear that requiring informed consent to transfer a patient to another medical facility abroad would require disclosure of any material medical information that the patient would need before making this decision.¹⁷⁴ Such material information should include (but should not be limited to): (1) where the alien will be sent, (2) what type of care the medical care facility abroad could/would provide to the alien, (3) how long the alien will remain in treatment abroad, and (4) the potential risk of material deterioration of the alien's medical condition if transferred abroad.

167. See BLACK'S LAW DICTIONARY 346 (10th ed. 2014) (defining informed consent).

168. See DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 30–32 (explaining the fundamental premise of the reasonable patient standard); see also R. Jason Richards, *How We Got Where We Are: A Look at Informed Consent in Colorado— Past, Present, and Future*, 26 N. ILL. U. L. REV. 69, 83–85 (2005) (explaining the fundamental premise of the professional standard).

169. DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 31.

170. *Id.*; see also Richards, *supra* note 168, at 83–85 (explaining the professional standard).

171. DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 31; see also Richards, *supra* note 168, at 83–85 (explaining the idea of the professional standard).

172. DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 30–31; see also Richards, *supra* note 157, at 85–87 (explaining the fundamental premise of the reasonable patient standard).

173. DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS, *supra* note 14, at 30–31; see also Richards, *supra* note 168, at 83–85 (explaining the reasonable patient standard).

174. Cantwell, *supra* note 120, at 259; see also BLACK'S LAW DICTIONARY 346 (9th ed. 2009) (defining the legal definition of informed consent as “a person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives”).

Obtaining informed consent should also be counterweighted with the alien's options should they decide to stay in the United States, including concerns such as how a hospital will or will not proceed with the alien's medical care.¹⁷⁵ Thus, requiring informed consent can serve as a potential barrier to aliens being medically repatriated, as it would require aliens to choose for themselves whether to remain in the United States or to return to their country of origin.¹⁷⁶ It would provide alien patients with the necessary information to determine what the best medical care option would be, as the hospital would have to present the aforementioned four factors to the alien patient.

B. Achieving Informed Consent—Immigration Consequences

Informed consent should consist of the alien patient obtaining the necessary medical information to make a decision as well as any potential immigration consequences. Aliens in the United States that are without status¹⁷⁷ are subject to harsh immigration consequences.¹⁷⁸ While it is difficult to make broad assessments as to what immigration consequences await an alien that is not within status (as every case is different), an alien without status will not be able to legally return to the United States for a long period of time once they return to their home country.¹⁷⁹ An alien that has been in the United States without status for certain periods of time is subject to applicable time bars that may last up to 10 years.¹⁸⁰ This is not to say that there will be no immigration ramifications should the alien patient

175. Cantwell, *supra* note 120, at 259–60. The alien should be aware of the consequences of remaining to stay in the United States. *Id.* For example, the alien should be aware of the hospital contacting the U.S. Department of Homeland Security to investigate the legal status of the alien patient. *Id.* The alien patient should also be aware of the positive health benefits of our health system should they decided to remain in the U.S. *Id.*

176. *Id.*

177. *See generally* Immigration and Nationality Act § 237, 8 U.S.C. § 1227 (2008) (noting that deportable aliens would include, but is not limited to, aliens that have entered the United States without admission, aliens that have overstayed their visa, or aliens who have fraudulently entered the United States and therefore were inadmissible upon admission to the United States).

178. *See generally* Immigration and Nationality Act § 212(a)(9)(B)(i), 8 U.S.C. § 1182 (2013) (explaining the various consequences that an alien who has been in the United States without status is subject to, including the consequence of the alien being forbidden to reenter the United States for a number of years).

179. *See generally id.* (explaining the various consequences that an alien faces).

180. *Compare id.* (explaining that if an alien patient has been unlawfully present in the United States for more than 180 days but less than a year, and then leaves voluntarily, there is a three year bar to reentering the U.S.), *with id.* § 212(a)(9)(B)(ii) (explaining that if an alien patient has been unlawfully present in the United States for one year or more, there is a ten year bar should they seek to return to the United States). This is just a brief mention of the various immigration consequences that could befall an alien patient should they decide to return to their home country.

decide to remain within the United States. With such extreme consequences from being in the United States without status, however, the alien patient needs to be aware of how their repatriation will affect their immigration status and future in the United States.

V. CONCLUSION

Congress created EMTALA and federal discharge requirements to prevent hospitals from turning away patients based on their inability to pay for medical care. These laws and regulations are ignored when sick alien patients are sent back to their home countries because they cannot continue to pay for hospital care. Aliens have tried to bring suit against these hospitals in the form of false imprisonment tort claims, but have been unsuccessful. As seen in *Cruz*, the court was able to find the alien patient's consent to medical repatriation through the alien patient's failure to object.¹⁸¹ This presents a troubling future for sick aliens.¹⁸² One way to stop medical repatriations is to require hospitals to obtain an alien's informed consent to medical repatriation. Informed consent should require not only explaining to the alien what the medical choices are before them, but also what immigration ramifications are possible.¹⁸³ These alien patients should be granted the autonomy to make their own medical decisions based on informed reasoning—requiring informed consent will grant alien patients this autonomy. It will also remain within the spirit of EMTALA and federal discharge laws, which was to prevent medical care facilities from rejecting patients because of their inability to pay. Furthermore, failure to obtain informed consent will serve as a basis for objecting to a medical repatriation. It is important to use medical ethics and laws to stand up for an underprivileged group in the U.S. healthcare system rather than manipulating these laws to the detriment of this group.

181. See *Cruz v. Ctr. Iowa Hosp. Corp.*, 826 N.W.2d 516, *4 (Iowa Ct. App. 2012).

182. See *supra* Part III (discussing implications of the *Cruz* holding).

183. See *supra* Part IV.